

Avoiding Patient Distortions in Psychotherapy with Borderline Personality Disorder Patients

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Patients with borderline personality disorder (BPD) have a reputation among psychotherapists for distorted thinking and misleading reports about their interpersonal relationships. This article discusses the difficulty in ascertaining whether seeming distortions are caused by true cognitive deficiencies or are instead caused by purposeful or subconscious manipulation of relationships. The tendency of BPD patients to use an impressionistic cognitive style that leaves out important details and leads to seemingly distorted reports may be related to the phenomenon of family invalidation. Empirical research into BPD distortions is reviewed. The article then describes techniques useful in psychotherapy for obtaining more factual and objective accounts of current relationship episodes. Transcripts from a therapy session are used to illustrate the techniques.

KEY WORDS: borderline personality disorder; psychotherapy; cognitive distortion; Unified Therapy.

INTRODUCTION

In clinical practice and in the literature, patients with borderline personality disorder (BPD) have long had a reputation for distorted thinking about what transpires in their interpersonal relationships (Kernberg, 1985; Noy, 1982). Kroll (1989) emphasized these patients' tendencies toward global perceptions with a loss of attention to details, alterations of meaning, spotty amnesia, and confused or contradictory descriptions of events and people. BPD patients are often characterized as engaging in "splitting," defined as the inability to integrate good and bad images of other people.

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Clearly, BPD patients often describe others *as if* they believe others are idealized paragons of perfection or denigrated embodiments of pure malevolence. They often describe interactional sequences in misleading or self-serving ways. They often recount the alleged misdeeds of others while systematically downplaying their own provocative behavior as a potential reason for them. They may accuse therapists, on the basis of seemingly harmless comments or the flimsiest of other evidence, of bad intentions.

Therapists from various schools are themselves split on whether these types of behaviors represent true cognitive deficits, defense mechanisms in the psychoanalytic sense, subconscious or intentional manipulation of others for ulterior purposes, or a combination of all of these. This question is an extremely important one for psychotherapists. If distortions prove to be true deficits in information processing rather than being motivated or planned behavior, treatment would have to be altered considerably. In fact, if there were some sort of permanent neurological deficit causing BPD patients to lack the ability to make more realistic assessments of their interpersonal environment, psychotherapy might not be very effective at all.

DIFFICULTIES IN EVALUATING THE NATURE AND CAUSES OF APPARENTLY DISTORTED THINKING IN BPD

As we know from empirical research as well as from cognitive psychotherapy experience, so-called “normal” individuals engage in the same types of distorted thinking seen in BPD patients rather frequently, although perhaps not so ostentatiously. Westen (1991) summarized a considerable body of research that shows that almost all people tend to look for and report information that is consistent with their pre-formed ideas while ignoring disconfirmatory information and make unrealistically positive self-evaluations. In the case of individuals exhibiting depression, cognitive therapists describe unrealistically negative global self-evaluations. In war time, for another example, enemy soldiers and their countrymen are often systematically dehumanized by combatants—that is, thought of as “all bad”—to make it easier to kill them. Americans, for example, referred to the Vietnamese as “gooks” during the Vietnam War. Such attitudes are often part of basic military training and indoctrination.

Normal individuals are, just as BPD patients, more likely to respond to interpersonal cues with black-and-white thinking—the cognitive therapy term for splitting—when they are upset with someone. When one is furious with someone else, one generally does not feel like saying or even believing a lot of nice things about the other person. Do BPD patients have a greater tendency to do this than patients who do not exhibit the disorder, or do they have more reason to be more upset with more people more of the time?

In a similar vein, it is very easy for most of us to have difficulty reconciling the behavior of other people if their behavior is very confusing. We all tend to entertain contradictory assumptions in such incidences. A prime example of this is often seen in the reactions of therapists to BPD patients. Are patients with the disorder master manipulators, or are they highly incompetent and ineffective at interpersonal influence? Individual therapists often seem to think both of these things at different times. BPD patients may at first idealize but later totally denigrate a parental figure, describing seemingly disparate and contradictory sets of parental behaviors to justify each characterization. It is certainly possible that the parent in fact frequently demonstrates both of these sets of behaviors, but at different times. In the experience of researchers into the family relationships of adults with BPD (Benjamin, 1993; Melges & Schwartz, 1989; Allen & Farmer, 1996; Allen, 2003), parents of offspring with BPD often do act in highly contradictory ways. It is likely that anyone, not just a patient with BPD, might try to sort through the resulting confusion by focussing on one set of these behaviors at a time.

A major difficulty that may preclude an accurate assessment of the apparent distortions of BPD patients is the near impossibility of designing reliable methods for separating mental deficiencies or incompetence from planned behavioral performance based on psychologically motivated interpersonal or intrapsychic objectives. Therapists in particular may be misled if they have no knowledge about the underlying motives of the individual exhibiting certain behavior. For example, if a BPD patient's goal were to provoke and anger a therapist for whatever reason, it would be a strategic blunder for the patient to throw in a few compliments. A tirade against the therapist might therefore falsely appear to indicate that a patient is capable of seeing the therapist only as "all bad" at that particular time. Similarly, if the patient's aim were to triangulate the therapist into a discordant relationship with a third party, it would be foolish for the patient to admit having provoked the third party into the very behavior being complained about.

The tendency of BPD patients to engage in a "hysterical" or histrionic thinking style (Shapiro, 1965), in which global judgments about the character of other people are substituted for actual descriptions of behavioral interactions, may also bias a therapist into thinking that a BPD patient is guilty of distorted thinking. If a patient describes her father as "controlling," the therapist really does not know what the patient means by this adjective, let alone on which behavioral patterns on the part of her father she is basing this characterization. Her definition may in fact be considerably different from what the therapist was initially led to believe. She may mean that he tries to control only certain aspects of her life when for other aspects he may go to the opposite extreme and enable her to do whatever she wants. He may be neglectful of her in yet other ways. On the basis of her statement, the accuracy of her perception is actually completely unknown to the therapist.

At best, all human language is inherently ambiguous (Allen, 1991). Any sentence in any language may mean a variety of different or even opposite things.

Phrases can be metaphors for unclear feelings or interactions. Words and statements can have multiple referents; the one to which a patient is referring may be unknown to the listener.

Patients with BPD may be particularly prone to use both ambiguous and histrionic language because of a phenomenon described by Marsha Linehan (1993), one of the leading theorists in the field of BPD. She describes the so-called “invalidating environment,” which she believes is characteristic of the interpersonal world of BPD patients and a major cause of the disorder. In such a setting, the patient’s perceptions are systematically denigrated, discredited, and disqualified by important others, particularly in the family. Even the internal feeling states of the patient are often mislabeled. In these situations, lack of strong feeling of certitude about one’s own thoughts and feelings may lead to the use of language that is extremely ambiguous. Worse yet, BPD patients may be condemned by significant others no matter which side of an issue they take (Allen, 2003). In such an instance, it is best for them to say things that can be interpreted in opposite ways as the need arises. The use of vague, globalistic, and impressionistic language is ideal for this purpose, as the listener cannot easily pin the patient down to a precise meaning. The BPD patient’s anxiety-generating conflicts may lead the patient to avoid making clear a stand on a particular issue. The patient may have a vested interest in keeping true perceptions, thoughts and feelings hidden from others and even themselves. The result is the use of language that may falsely appear to indicate distorted thinking patterns.

EMPIRICAL RESEARCH INTO BPD PATIENT DISTORTIONS

Empirical studies that directly address the question of whether any seeming distortions reported by BPD patients represent actual cognitive deficiencies, are feigned, or are motivated intentional (or subconscious) behavior are virtually nonexistent. One study (Sternbach, Judd, Sabo, McGlashan, & Gunderson, 1992) asked clinicians to provide their own clinical vignettes and merely describe their impressions about distortions in a group of BPD patients compared with a group of schizotypal personality disorder patients. However, there were no standardized criteria for determining how such judgments should be made nor concrete operational definitions of the phenomena under study. The impression of these clinicians was that schizotypal patients had significantly more cognitive distortions than BPD patients did. The distortions attributed to BPD patients were felt to be related primarily to interpersonal interactions. Even then, they were thought to appear only intermittently and to occur primarily in the midst of emotionally stressful transactions.

Studies that rigorously address the empirical accuracy of the verbalized reports of BPD patients are few in number, often demonstrate contradictory results,

and often do not study social cognition in the context of relationships with people with whom subjects have strong feelings and prior knowledge. As mentioned, these studies do not clearly distinguish between performance and innate abilities. Studies that indirectly relate to this question fall into three categories. First, social cognition is studied by having subjects identify emotions in photographs of strangers or in videotaped vignettes or scoring recounts of descriptions by patients of the motives of others in certain situations on the basis of various models of “developmental” complexity. Second, patients are studied for signs of neurobehavioral deficits and brain dysfunction that may lead to distorted thinking.

In the third category, BPD patients are asked to recall events from their childhood. In some studies, stories of childhood adversity are checked against whatever hard data may exist about what really happened. Other studies in this category ask subjects for retrospective assessments of parental figures. Studies in this third category are quite numerous and have been extensively reviewed elsewhere (Nickell, Waudby, & Trull, 2002; Gunderson, 2001; Zanarini & Frankenburg, 1997; Links & Munroe-Blum, 1990). They will not be reviewed again here. The sheer cumulative weight and consistency of this category of studies, however, argues for the veracity of reports by subjects with BPD of an extremely high incidence of trauma in their childhood family relationships.

However, critics of these studies maintain that they do not prove anything about the accuracy or distorted nature of such reports, for a number of reasons. Often the stories involve accusations by subjects of childhood abuse, some of whom claim to have had “recovered memories.” The events usually took place many years before the study. Such studies are both extremely difficult to design and highly unreliable due to the fact that abuse, where it does occur, is often witnessed only by the perpetrator and the victim. We still do not have an accurate way to tell who is lying and who is telling the truth. Furthermore, since it is widely agreed that human memory in general is imprecise and unreliable at best, the fact that someone is wrong about one detail of a recalled event years after the fact tells us nothing about whether or not that person is correct about other details, let alone the big picture.

Studies that ask subjects for retrospective assessments of parental figures present another difficulty when it comes to using the data to evaluate how much distortion may be involved. They usually call for global judgments about parental characteristics by patients without providing them the opportunity to provide detailed descriptions of the supposed interactions upon which their conclusions were based. Under such circumstances, there is no real chance for patients to demonstrate any understanding of complexity. The only exceptions to this latter problem are studies using the Adult Attachment Interview (George, Kaplan, & Main, 1985). This instrument does allow patients to engage in extended discourse about their attachment experiences, although the use of standardized questions may interrupt their flow of speech or induce emotions in them (Buchheim & Mergenthaler, 2000).

So far, however, we know of no studies in which these recollections were tested for empirical accuracy.

On tests of facial expression recognition ability, Wagner and Linehan (1999) found that BPD patients exhibited no deficiencies in their ability to accurately perceive others' emotions and indeed were more sensitive to recognition of fear than normal controls. This study contrasted with the results of Levine, Marziali, and Hood (1997) that showed that BPD patients were less accurate at identifying facial expressions of emotions. Wagner and Linehan hypothesize that the difference in the two studies may be due to a lower number of stimuli tested in the latter study, thereby leading to less accurate assessment of ability, as well as to the fact that males, who generally perform more poorly on such tests, were included in the Levine sample. Camras, Grow, and Ribordy (1983) found that abused children were less skilled in decoding facial emotional expressions than nonabused children, but the researchers did not study adults.

The results of the Levine et al. study (1997) also showed that BPD patients had more intense responses to negative emotions, less emotional awareness, and less capacity to coordinate mixed valence feelings. However, Herpertz et al. (2000) compared general affective hyperresponsiveness in BPD patients to avoidant personality disorder patients and found no differences in either their self-reports or in physiological measures of skin conductance, heart rate, or startle response. These studies are probably measuring phenomena related to affect regulation rather than cognitive distortion *per se*.

Frank and Hoffman (1986) studied identification of emotional content by BPD patients through videotaped vignettes, while Ladisich and Feil (1988) compared BPD subjects' assessment of other subjects compared with the latter subjects' self-assessment. BPD patients were actually superior to comparison groups in these studies. Marziali and Oleniuk (1990) studied spontaneous descriptions of parental figures in a very small sample of BPD and comparison patients and scored them on a five-point scale that purportedly measured "levels of object differentiation." The lower level was scored when the patient seemed to describe the others in ways that only related to whether the "object" gratified or frustrated the patient's needs. At defined higher levels, subjects appeared to be able to "resolve and integrate more complex and contradictory meanings of the subject's attributes" (p. 109). Both BPD and non-BPD subjects exhibited descriptions that were scored at all five representational levels, but the BPD patients had a higher concentration of scores at the lower levels. The results, possibly because of the small sample size, were not statistically significant.

Studies of neurobiological deficits also reveal contradictory but generally negative results. Findings that do show up tend to be somewhat disparate, and any single finding is seldom seen consistently in a majority of the BPD subjects under study. Cornelius et al. (1989) reviewed studies that found no differences between BPD patients and controls on age of attainment of developmental milestones, hyperkinesia, clumsiness, speech defects, mildly abnormal EEGs, family history of

neurological disorders, or consistent patterns of abnormalities on neuropsychological testing. On intelligence testing, they found that the WAIS scores of BPD patients had means and ranges very similar to those of the general population. In contrast, Swirsky-Sacchetti et al. (1993) found significantly lower scores by BPD patients compared with controls on verbal, performance, and full-scale WAIS IQ scales, as well as on tests on motor skills, figural memory, complex visuomotor integration, and social intelligence. However, these results are difficult to generalize because of a small sample size of 10 subjects, 8 of whom were on psychotropic medications. Schubert, Saccuzzo, and Braff (1985) found no difference between BPD patients and normal controls on a task that measured speed of information processing.

O'Leary, Brouwers, Gardner, and Cowdry (1991) ran batteries of many different neuropsychological tests on BPD patients. Their findings must therefore be tempered with the understanding that some of the positive results reported may have occurred only by chance. They found significantly lower scores by BPD patients compared with normal subjects on a minority of subtests of the WAIS and on about half of their tests for disturbances in visual perception. Some of the positive results, such as decreased performance on the digit-symbol subtest of the WAIS, are difficult to relate to the kind of distortions described by clinicians. An interesting finding was that BPD patients performed worse on recalling complex, recently learned material if no cues were given, but that cueing the patients partially corrected the deficit. This may reflect the BPD patient's impressionistic cognitive style more than any true memory defect.

Van Reekum, Conway, Gansler, White, and Bachman (1993) and Van Reekum et al. (1996) studied two cohorts of BPD patients who exhibited an extremely high incidence of a history of brain injuries and found a significant number of "soft" neurological signs and abnormalities on neuropsychological testing indicative of frontal lobe dysfunction. These cohorts were probably atypical for the general BPD population, as to our knowledge no other authors have reported such a high incidence of brain trauma in the histories of BPD patients.

PATIENT "DISTORTIONS" IN FAMILY SYSTEMS ORIENTED INDIVIDUAL PSYCHOTHERAPY WITH ADULT BPD PATIENTS

Unified Therapy (Allen, 1988, 1993, 2003) is an integrative psychotherapy for adults with Cluster B and C personality traits. It postulates that dysfunctional character traits and chronic anxiety and depressive symptoms are both triggered and operantly reinforced by recurring and ongoing dysfunctional relationship patterns between the patient and leaders of the patient's family of origin. Therapy is designed to teach patients strategies for discussing the nature and origin of these patterns with family members in ways that allow for the pattern to change. In order for such strategies to be effectively designed, it is extremely important

that the therapist not only understand why patients have strong emotional reactions to certain issues, but obtain reasonably accurate descriptions of repetitive, present-day interpersonal family interactions over those issues. When the first author (D.A.) first started trying to do this work with patients with BPD, the question arose as to whether the patient had the ability to provide sufficiently accurate descriptions. The first clue that they could do so was when patients would admit later in therapy that their apparent distorted thinking in earlier treatment was far more purposeful than most therapists would imagine. They also admitted that they were often well aware that they had been expressing themselves in misleading ways.

A good example is the case of a man who was followed for several years in my (D.A.) psychiatric residents' clinic at the University of Tennessee before finally coming to see me for treatment. Resident therapists would hand the patient over to a different resident at the end of their year-long outpatient training experience. I had the opportunity to directly observe many of the sessions through videotape during group supervision. What was most striking about this patient was his incredible consistency over several years and with different therapists in seeing himself in a negative light. He said that he saw himself as utterly inadequate in almost all spheres of human activity, including work and relationships. He said he really believed this to be the case because it was an absolute, incontrovertible truth; it was in no way just an irrational cognition he could not let go of. No amount of cognitive disputation or psychodynamic interpretation seemed to have the slightest effect on his seemingly unshakable belief about himself. He also consistently said that, no matter how well he might have done anything, it was really not good because he should have done even better. However, in situations in which he might have actually done better, he would never actually strive to do so. He would either set clearly unreachable goals or somehow stop his efforts just short of achieving reasonable ones. When he started therapy with me, he continued to think of himself and behave in these ways. At one point, I asked him to pretend that I had a magic wand that allowed him to actually become a success and feel good about it and to visualize what that might be like. He said he was unable to even fantasize about such a thing; it would never be possible due to all of the previous opportunities he had blown. He then began to despair about how he was inadequate at even doing the task I had just assigned him.

After more than two more years of therapy twice a month, he on one occasion actually acknowledged that he had done something right and joked about how insane his tendency to constantly denigrate himself was. I replied that I was pleased that he was finally beginning to consider the possibility that his earlier thoughts were somewhat silly. He replied, to my amazement, "Oh, I *always* knew they were silly; I just couldn't stop thinking them!"

Over the years, I had had several patients make similar admissions. I began to find consistently that much of the BPD patient's apparently distorted thinking

evaporated if the therapist knew what questions to ask and how to ask them. I began to gather data on the accuracy of the patient's reports about interpersonal interactions gathered under this type of therapy by using a variety of sources. I invited important family members into sessions and elicited their side of the story and had some of them come back to me later for individual psychotherapy themselves. I listened to audiotaped telephone conversations between BPD patients and their parents that patients brought in unsolicited to prove that they were telling the truth about their interactions, and watched videotapes of family therapy sessions led by therapist trainees. I have also watched independently recorded videotapes of mothers and their adult borderline daughters, each in individual psychotherapy with different therapists, discussing their views about the very same examples of their interaction. Last, I have gathered letters and other written communications that patients have received from parental figures over the years.

Although this data was qualitative, unsystemitized and not controlled, precluding quantitative analysis, the resulting highly detailed case studies (Allen, 2003; Allen & Farmer, 1996) and clinical experiences led me to the conclusion that even severely disturbed BPD patients have the ability to relate reasonably objective accounts of their ongoing family interactions.

TECHNIQUES AND STRATEGIES FOR MINIMIZING DISTORTIONS

This section will review several techniques and strategies for obtaining from BPD patients relatively factual, undistorted descriptions of their ongoing interpersonal interactions as adults. An essential caveat to what follows is that the techniques to be described are useful only *after* the therapist has formed a good relationship with the patient and has adequately addressed patient acting out within the transference relationship and other patient behavior that interferes with the process of therapy. A review of techniques used for accomplishing those objectives is beyond the scope of this article; they are described in detail elsewhere (Allen, 1997, 2003). A more complete description of the use by therapists of linguistic principles to suggest questions to pose in order to clarify ambiguous patient communication is also described elsewhere (Allen, 1991).

The most important factor in obtaining accurate descriptions of interpersonal behavior patterns of BPD patients is the therapist's attitude. The therapist must strongly believe and convey the attitude that BPD patients are as capable of accurately reporting events in their lives as anyone else and automatically expect that they will do so if given the opportunity. The therapist assumes that patients really want to help the therapist understand what is going on. If BPD clients do not always accurately relay information, it is only because of fear of how the therapist might respond or because the therapist has not clearly conveyed to the patient exactly what information the therapist is trying to ascertain.

FEARLESSLY INQUIRING ABOUT APPARENT HOLES AND CONTRADICTIONS IN THE PATIENT'S RELATIONSHIP VIGNETTES

Even when patients appear to be relating relationship episodes in an exaggerated, incomplete, contradictory, or self-serving manner, it is fruitful for the therapist to avoid any implication that the patients are misleading the therapist or to overtly accuse them of it. There is always some truth to whatever the patient is saying; the therapist's job is to uncover exactly how the patient's descriptions are true. In order to do this, the therapist must first recognize exactly what information is missing or ambiguous and then fearlessly ask the patient to elaborate or further clarify any apparent confusion or contradiction. Despite their reputation for emotional fragility, BPD patients often respond well to the anxiety-provoking technique (Sifneos, 1992) of the therapist pursuing the subject until the patient tells the whole story.

In order to reduce a patient's fearfulness and defensiveness that may lead to distorted accounts, a highly useful technique is the so-called "Columbo" style of questioning (Donald Meichenbaum, personal communication). This technique is named after a fictional TV detective who would induce criminals into confessing their crimes by acting befuddled with them when discussing the evidence at hand. When a patient relates something that does not seem to make complete sense or which seems to contradict something said earlier, the therapist asks for the patient's help in understanding the apparent confusion. The key is that the therapist approaches the client from a "one down" position. That is, the therapist does not imply that patients have not expressed themselves clearly or that they are "in denial" about the confusion or that they are manipulating the therapist. Rather, the therapist attributes the confusion to an inability to make complete sense of what the patient is saying. It is the therapist who is not quite sharp enough at that particular moment and just "does not get it."

When approached in this way, patients seem to be naturally induced to be more helpful to the bumbling therapist by clarifying the confusion. If the patient makes no effort to help the therapist in this way or if the efforts do not succeed, the therapist further responds in a way that suggests frustration with the therapist's own abilities to understand what is transpiring. If the patient still does not respond, the therapist must make a decision as to how hard to push the patient for more "help." Early in therapy, before the patient has confidence in the therapist, it is probably best to push only a little and then back off while indicating that the therapist will come back to the issue later. It is important to indicate to the patient that the therapist is not avoiding any potentially anxiety-provoking subjects. Later in therapy, we recommend becoming more insistent on getting clarification.

A clinical example of the use of this technique occurred during therapy of a woman whose child was being raised by her parents. According to the patient, her parents had consistently told her over many years that she was an incompetent individual who could not be trusted with the child because she had, in the past,

behaved recklessly. The patient relayed a long history of having had her general adequacy as an individual denigrated in similar ways by her parents. It seemed to the therapist that she was painting a rather one-dimensional picture of her parents, but she was quite consistent. Somewhat later in therapy, after a visit to her parents, however, she related a story about having been asked by both of them to mediate a dispute they were having with her sister. From her description, it sounded as if her parents actually looked up to her in some ways as a trusted advisor. While this did not directly relate to the issue of her competency as a parent for her own child, it seemed to the therapist to be somewhat contradictory to the patient's previously described opinion about her parents' view of her.

The therapist then said, "I'm a little confused. I know the issue of your parents wanting you to mediate their dispute with your sister is a little different from their opinion about your parenting abilities with your own daughter, but now it sounds like they sometimes think you might be more competent at parenting than they are." The client initially reacted as if she did not understand what the therapist was getting at, and became rather tangential. The therapist inquired as to whether or not the patient understood the question being posed. After a bit of persistent questioning by the therapist, the patient admitted that she also found the parents' attitude shift confusing and related a history of other such shifts. A more complex picture of her interactions began to emerge.

JUDGMENTS MASQUERADING AS DESCRIPTIONS

As previously described, when first asked about a particular interactional relationship episode, patients with BPD often respond with global, impressionistic judgments about the people involved. Unless asked, they may not volunteer a specific description of interactions that have taken place that have led to this judgment. To find out what the patient means, the therapist needs to ask for behavioral descriptions, not just the patient's opinions regarding other people's personalities. To continue with the example of a client who described her father as "controlling," the therapist would learn much by asking the patient the following types of questions: What do you mean, in behavioral terms, by "controlling"? What is your father doing and saying that indicate that he wants to control you? What do you believe to be his motives for wanting such control, and on what do you base this belief? What part of your life do you think he wants to control? What exactly is he trying to get you to do or not do? How does he go about trying to control these aspects of your life? Under what circumstances does he act in such a manner, and under what circumstances does he not act that way? What are you doing or saying that might be provoking a "controlling" response?

To better understand the relationship between the patient and the father, it is important to obtain a concrete description of the behaviors the father engages in that lead the patient to use the term "controlling." To do so, therapists should act

like investigative reporters asking for specifics using follow-up questions. They can ask for clarification of vague or confusing statements and inquire about seemingly insinuated but unspoken implications. If the patient responds to requests for descriptions of specific behavior with more vague global generalizations, the therapist presses for some prototypical examples. Even after an example of an interaction is finally given, it may still be necessary to ask for further clarification. If the patient's description of the father would lead the therapist to a conclusion at odds with the patient's, the therapist might express curiosity about why and how the patient came to the conclusion she did.

In obtaining concrete descriptions of interactions rather than globalized judgments, it is also important to find out what the people in the described relationship vignettes, including the patient, actually said to one another. Finding out specifically who said exactly what to whom in reported conversations that were conflictual, adversarial, or anxiety-provoking for the patient often adds a tremendous amount to the therapist's understanding of the patient's relationship system. Patients who may otherwise omit important details often are able to provide very accurate details of affect-rich conversations because such conversations are so emotionally salient for the patient. Importantly, the therapist should try to elicit as much as possible about the whole conversation, not just the beginning of it. The way conflictual conversations end may provide important details about the patterns of mutual invalidation that often characterize communication in families with BPD members. Statements by patients such as "Mom did not respond at all after I told her that" are ambiguous and should trigger requests for clarification from the therapist. What did Mom actually do at the point of "no response"? Did Mom turn around and walk out of the room? Stare silently into space as if in a trance? Roll up into a fetal position? The answer to such questions allows the therapist to better understand the patient's need for avoidance and ambiguity in their discussions of important issues.

The more specific and detailed the questions the therapist asks, the more accurate the picture of the patient's relationships becomes. If the patient seems reluctant to give concrete examples of family interactions, the therapist once again needs to make a clinical judgment about how hard to push for them. As with other anxiety-provoking techniques, therapists usually should not push as hard in the first few sessions as they do later.

DESCRIPTIONS MASQUERADING AS EXPLANATIONS

In attempting to obtain an undistorted or honest explanation of a patient's conscious reasons for engaging in a particular course of action, the therapist can be alert to instances of descriptions masquerading as explanations. Often, when a therapist asks patients to explain their motives for certain behavior or the reasons they are fearful of some action, they respond by paraphrasing an earlier description

of their state of mind. The response sounds like an explanation for their motives or fears but in fact explains nothing. Here once again, the use of follow-up questions is essential in clarifying the patient's actual motives.

The most common example of a description masquerading as an explanation is the statement, "I won't do such and such because I don't like doing that" or "I do it because I like to." This sort of "explanation" might be used to explain away extremely self-defeating behavior such as getting oneself fired from jobs due to frequent confrontational behavior or habitually getting involved with a series of mates who exhibit the same obvious dysfunction. In such cases, the patient seems to be saying that the decision to choose or avoid a course of action is based merely on a personal idiosyncrasy, on the order of not particularly enjoying the sport of bowling. It is more likely in such cases that the decision is based on past experiences with the course of action in question. Usually there was a history of unintended adverse consequences to making the "healthier" choice. The therapist needs to ask patients specifically what they think might happen if they were to do so. What are the plusses and minuses that went into the patient's decision, and what makes the patient give a lot of weight to some of them and little weight to others? Are the feared consequences sufficiently onerous to account for the patient's behavior?

A variation on this theme is the patient who attributes an aversion to an essential course of action to a simple phobia, perhaps based on a single traumatic incident in the past. One patient refused to go to school to get retrained after an on-the-job injury halted her previous career. She said she was just "uncomfortable in classrooms" because of an incident in which her seventh grade English teacher embarrassed her in front of the class. The problem with this "explanation" is that just about everyone has been embarrassed by his or her seventh grade English teacher. While the event probably had something to do with her apparent aversion to school, there just had to be something more than that. Follow-up questions might include, Did something else happen after the event? What was the reaction of your parents to what your teacher did? What seems to make you focus on this event? Why do you think you are unable to overcome it? What have you done to try to overcome the problem, and if nothing, why? If the patient replies to the latter question with, "I just didn't think there was anything I could do about it," the therapist should inquire if the patient had even looked into possible solutions, and if not, why not.

HANDLING STRONG AFFECTS

BPD patients are known for having a "dysregulated" affect. They exhibit very high levels of the personality trait of neuroticism (Clarkin, Hull, Cantor, & Sander-son, 1993), defined as a tendency toward easily being becoming highly emotional, depressed, panicky, or irate. Some authors feel that this apparent dysregulation is

a result of some sort of genetic disorder of limbic system function. Such patients may in fact show disturbances in the hypothalamic-pituitary axis, although the best evidence is that this is caused by a sort of “ongoing posttraumatic stress disorder” resulting from having lived in an abusive environment.

Regardless of whether or not such a neurological deficit exists, when BPD patients are experiencing an affective storm, it becomes less likely that they will be able to coolly report objective details about problematic interactions. They will tend to resort to emotional hyperbole and to substitute gross judgments for facts. For this reason, the therapeutic standby of “getting patients in touch with their feelings” at times works against their reporting factual data. In a similar vein, many therapists treating victims of physical and sexual abuse think it a good idea to have patients review traumatic memories in excruciating detail so that the patients will become desensitized to them. We find that doing this tends to cause them to relive the trauma, which has the exact opposite effect. It is analogous to locking a patient with an elevator phobia in an elevator to use the techniques of “flooding,” but letting them out before their anxiety level returns to baseline. The result is that the new anxiety becomes classically conditioned to the old, and the overall level of anxiety goes up. Addressing the effects of childhood abuse, and its relationship to ongoing conflictual family interactions, is far more important than obtaining precise descriptions of the actual events. (A discussion of the current heated debate over whether a therapist has a duty to attempt to confirm the veracity of childhood abuse accounts is beyond the scope of this article).

However, in what may be seen as a contradiction to the above discussion, the unified therapist never avoids touchy subjects because of fearing that the strong emotions engendered will be too destabilizing to the patient. As discussed earlier, to get objective descriptions of interpersonal interactions, the therapist must fearlessly confront subjects about which the patient is highly disturbed.

The therapist does not have to directly witness a rage or a panic attack by the patient to know that the patient has them. If a client has one in a session, little work will be done. Hence, in Unified Therapy, the therapist strives to keep the session as calm as possible. Medications are frequently used to keep affective symptoms to a minimum. They often help the patient stay more composed when discussing subjects that might otherwise lead to an affective attack.

If patients are “in denial” about strong feelings about a particular subject, the unified therapist will generally not argue with the patient about it, provoke the feeling, or interpret the defense. In other words, the therapist supports or even subtly encourages the use of the defense mechanism of isolation of affect by the patient. Patients who deny anger at someone else but who go on to list more and more complaints about that person are actually strongly agreeing that they are angry. Patients who deny caring about family members but who go on to describe the many sacrifices they make for them are likewise contradicting their denial. The therapist who tries to get them to agree to a label for their troublesome emotions will probably end up stirring them up. Such insistence becomes counterproductive

and is avoided so that the patient may continue to report important information in a relative modulated state of mind.

The only exception to this rule is when the patient is in such denial about the amount of affect they feel over a dysfunctional interpersonal relationship pattern that they deny its importance in the genesis of their affective symptoms and self-destructive behavior. Since they are so irrelevant, patients may argue, there is no need for the therapist to focus on them. In this case, the fact that the patient experiences a strong affective reaction whenever such interactions are mentioned is tactfully pointed out by the therapist. The therapist then indicates that the presence of such strong feeling indicates that that subject is a major trigger of the patient's symptoms and therefore needs to be discussed.

CASE EXAMPLE THERAPY TRANSCRIPT

Therapy transcripts from a patient followed by the second author (S.W.) illustrate some of techniques described above. The patient initially described a family interaction in an overly global and misleading way. With persistence, the therapist encouraged her to give the details of the event. The patient then provided many such details, some of which revealed less than flattering descriptions of her own culpability in the problematic interactions. In addition, her elaboration elicited additional information that the therapist might not have otherwise known.

Later, she described material from her history about somewhat parallel interactions with her parents in the past. During these earlier episodes she reported that her parents had routinely and systematically invalidated her feelings and experiences. The parallels between the current and earlier episodes were highly consistent with ideas described above concerning the role of invalidation in leading to distorted patient reports. The earlier invalidation may explain her having resorted to broad generalizations initially rather than having shared details of the incident.

During the course of therapy, this woman in her mid-20s described an acrimonious relationship with her father. She was particularly upset about a series of events that had led to legal charges against her. She saw her father as the initiator of the court proceedings. In her initial descriptions of the events, she provided a global judgment with a self-serving bias as seen in the transcript below:

Patient: I'm in a couple of different court cases with him [my father] right now because he made up stories . . . complete fabrications . . . This one court case we have trial set for January 3rd . . . We all went to jail on aggravated assault among many other charges, and the prosecutor tried to drop it. The judge wants to drop it. It's obvious my dad's friend is helping my dad. We're completely innocent. It's just a long story of lies.

During the next session, the therapist had an opportunity to revisit the event to get a better sense of what actually occurred:

Therapist: What about the case with you—you never did tell me exactly what happened? Is he [your father] pressing charges against you or against your boyfriend?

Patient: It's not my dad exactly. Once it got to a certain point in the courts, it was turned over to the state, but John didn't even show up.

Therapist: What happened previously?

Patient: There was a hearing and because John didn't want to drop it then and there, it turned over to the state but John didn't even show up.

Therapist: Who's John?

Patient: He's the one all of us were fighting with.

Therapist: So are the charges against you?

Patient: Me and the other two people with me.

Therapist: What happened exactly?

Patient: It's a long stupid story. It's all lies.

Therapist: Then what really happened?

At this point, the patient described the event in elaborate detail. She reported that she and two of her male friends had gone to her father's house without his permission while he was away. As they were leaving, they were stopped by a neighbor who reprimanded them and called the police. She described in great detail some of the events as they were trying to leave, as seen below:

Patient: I pulled up. Put my hands up like "What are you doing?" He didn't move. I didn't hit him . . . I pulled forward, touched his car, and accelerated. Nothing happened. I backed up . . . Barry and Robert get out of the car and came around to the driver's side. He [John] gets out and grabs Barry's hair—and starts tearing him around. Barry is screaming, holding onto his hair so he can't pull it out. Robert grabs John . . . Whole time I'm watching this big fat ogre fight with my friends. I'm like—what can I do. So I just kick him a couple of times. I'm screaming at him and I thought if I bite his hand he's holding on to the hair with he will let go. So I did that.

Thus, when encouraged, she not only gave more concrete details but also indicated that she was responsible, at least in part, for the charges she incurred. In addition, she further incriminated herself during the telling of this story by relaying to the therapist other unrelated illegal activities that she had previously been involved in but with which she was never charged.

Later in the session, the patient revealed that during her childhood her parents often minimized or blatantly denied upsetting family events that had occurred and in which the police were involved:

Patient: "We were taught not to trust ourselves" [patient was reading from a book she brought to the session, *Codependent No More*]. I don't. That's why I'm

always like—maybe I should do this, maybe I should do that. I don't trust myself at all—anything I do or say generally speaking. [She begins to read more:] "This happens when we have a feeling and were told it's wrong or inappropriate." That happened all my life. "Or when we confront a lie or inconsistency and we're told we're crazy."

At this point, the patient shook her head in agreement with the last statement.

Therapist: Tell me about some of those things that have happened.

Patient: Like all the times we called the police and they left and we [the children] were the ones who were out of line.

The patient went on to explain that when her father became violent and the children called the police in fear, it was they who were chastised rather than the father, and their experience was disqualified. This repetitive experience of invalidation about a particular issue over the years may provide an explanation for her initial reluctance to provide actual details of her recent encounter with the police.

CONCLUSION

Patients with BPD can often be much more reasonable and competent in describing their lives than they are given credit for. Their reputation for distortion, although based on real, prevalent, and salient clinical behavior, seems to be more apparent than due to a real cognitive impairment. Patients with BPD may provide a distorted account more purposefully, and with far more awareness of its distorted nature, than a therapist might expect. Clinicians may inadvertently create distortion iatrogenically by too easily assuming that the patient is cognitively deficient. A validating and empathic but still forceful approach to the patient can lead them to give the therapist accurate descriptions of their interpersonal relationship patterns.

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